# MHS **Professional** & Facility **Billing** 2020



















## **Agenda**

- **W** MHS Overview
- **W** Claim Submission Process
- **W** Adjustments & Timelines
- Prior Authorization
- **Dispute Resolution Process**
- **Web Portal Functionality**
- Professional Billing
- **W** Facility Billing
- **WATER** MHS Team
- **Summary**
- **W** Questions



## **MHS Overview**



## Who is MHS?

- Managed Health Services (MHS) is a health insurance provider that has been proudly serving Indiana residents for two decades through Hoosier Healthwise, the Healthy Indiana Plan (HIP) and Hoosier Care Connect.
- **MHS** is your choice for better healthcare.



## **MHS Products**









## **Claim Submission Process**



## **Medical Claim Submission**

### **W** Electronic Data Interchange Submission:

- Preferred method of claims submission
- Faster and less expensive than paper submission
- MHS Electronic Payor ID 68069

### Online through the MHS Secure Provider Portal at mhsindiana.com:

- Provides immediate confirmation of received claims and acceptance
- Institutional and Professional
- Batch Claims
- Claim Adjustments/Corrections
- Claim review/Adjustments request

## **Paper Claims:**

Managed Health Services PO Box 3002 Farmington, MO 63640-3802



# **Behavioral Health Claim Submission**

### **W** Electronic Submission:

- Payer ID 68068
- MHS accepts Third Party Liability (TPL) information via Electronic Data Interchange
- It is the responsibility of the provider to review the error reports received from the Clearinghouse (Payer Reject Report)
- Online Submission through the MHS Secure Provider Portal:
  - Verify Member Eligibility
  - Submit and manage both Professional and Facility claims, including 937 batch files
  - To create an account, go to: mhsindiana.com

### **Paper Claims:**

- MHS Behavioral Health PO Box 6800 Farmington, MO 63640-3818
- **W** Claim Inquiries:
  - Check status online
  - Call Provider Services at 1-877-647-4848



## **Claim Submission**

Contracted or In-Network providers: 90 calendar days from the date of service or discharge date.

## **W** Exceptions:

- Newborns (30 days of life or less) Claims must be received within 365 days from the date of service. Claim must be filed with the newborn's RID #.
- TPL Claims with primary insurance must be received within 365 days of the date of service with a copy of the primary Explanation of Benefits. If primary EOB is received after the 365 days, providers have 60 days from date of primary EOB to file claim to MHS. If the third party does not respond within 90 days, claims may be submitted to MHS for consideration. Claims submitted must be accompanied by proof of filing with the patients primary.



## **Claims Submission**

## Claim Acceptance & Adjudication

- System reviews claim for errors and critical fields (i.e. dates of service, billing/rendering provider, etc.) prior to acceptance.
- Regulatory requirements (federal and state) mandates certain information to be present in order to accept and pay a claim.
- NPI common rejection/denial; provider information on claim <u>must</u> match record at IHCP enrollment a State requirement.



## **Transportation Claims**

- Beginning with dates of service May 1, 2019 and after, Managed Health Services (MHS) will process all Medicaid emergent and non-emergent ambulance claims, including air ambulance, which would have previously been processed by LCP Transportation.
- Claims for the following services should be sent to MHS starting with date of service May 1, 2019:
  - 911 Transports
  - Medically necessary non-emergent hospital transports requiring an ambulance with advanced life support (ALS) or basic life support (BLS).
  - Air ambulance
- Only providers enrolled with the Indiana Health Coverage Programs (IHCP) are eligible for reimbursement. Claims must be filed within 180 days of the Date of Service date of service for non-contracted providers and within 90 days of DOS for contracted providers.
- Claims should be submitted to MHS via a CMS-1500 professional claim form. Claims may be submitted via EDI (preferred), MHS web portal or paper.



## **Transportation Claims**

W MHS will follow IHCP billing guidelines for coding and reimbursement.

For more information on Medicaid ambulance billing guidelines, please visit <u>in.gov/medicaid/files/transportation%20services</u>.

### **W** Claim Inquiries:

- Check status online
- Call Provider Services at 1-877-647-4848



## **Claim Billing with Ease**

- **W** NPI, Tax ID, Zip +4
- This information is necessary for the system to make a one to one match based off of the information provided on the claim and the information on file with Indiana Medicaid.
  - Member Information
  - Newborn's RID number is required for payment
- **W** Attachment Forms:
  - Required forms need to accompany the claim form
- **Secondary Claims (TPL):** 
  - Accepted electronically from vendors or via the MHS Secure Provider Portal



# **Laboratory Billing**

All providers that bill laboratory services on a CMS-1500 form must have Clinical Laboratory Improvement Amendments (CLIA) certification or a CLIA waiver certification equal to the procedure code being billed, and included on the CMS-1500.

EXc1 DENIED: INVALID CLIA NUMBER: This verification will ensure that MHS is compliant with the CMS guidelines.



## **Laboratory Billing**

Physician's Office Lab Testing (POLT)

Policy CC.PP.055 To ensure laboratory tests are performed in the correct setting, the health plan will limit the performance of in-office laboratory testing to the CPT® and HCPCS codes listed in the Short Turnaround Time (STAT) laboratory (lab) code list included in this policy.



## **Laboratory Billing**

- These are tests that are needed immediately in order to manage medical emergencies or urgent conditions. To this end, specific clinical laboratory tests have been designated as appropriate to be performed in the office setting.
- The health plan's automated claims adjudication system will deny in-office (location 11) laboratory procedures that are not included on the STAT lab list found on the MHS Indiana website
- Policy can be found <a href="https://www.mhsindiana.com/content/dam/centene/mhsindiana/policies/payment-policies/CC.PP.055.pdf">https://www.mhsindiana.com/content/dam/centene/mhsindiana/policies/payment-policies/CC.PP.055.pdf</a>



## **Claim Rejections**

## Claim Rejection

A rejection is an unclean claim that contains invalid or missing data elements required for acceptance of the claim in the claim process system.

Timely filing is not substantiated.

Rejected claims may be corrected and resubmitted as a 1<sup>st</sup> time claim. Examples of rejected claims

- Provider/practitioner not enrolled in IHCP
- Invalid member RID number
- Incorrect type of bill for the service or location
- Missing or invalid modifier



# **Claim Rejections**

- EDI rejections require the provider to contact their clearinghouse and obtain a payer rejection report.
- Paper to electronic mapping is available on <u>mhsindiana.com/provider-guides.</u>
- MHS website tools :
  - Reject code listing
  - Refer to top 10 rejection code help aid document



# MHS Provider Claims Issue Resolution Process



## **Provider Claims Issue Resolution**

### **PROCESS**

- Step 1: Informal Claims Dispute or Objection Form
- Step 2: Formal Claim Dispute Administrative Claim Appeal
- Step 3: Arbitration
- For assistance or questions after completing step one:
  - Provider Services Phone Requests & Web Portal Inquiries
- If additional assistance is needed anytime after Step 1 and after calling Provider Services or completing Web Portal inquiry:
  - Provider Relations Regional Mailboxes



- Must be submitted within 67 calendar days of receipt of the MHS Explanation of Payment (EOP):
- By using the MHS Informal Claim Dispute or Objection form, available at <a href="mailto:mhsindiana.com/providers/resources/forms">mhsindiana.com/providers/resources/forms</a>; there is a general form for medical and a separate form for Behavioral Health claims. The address for submission is listed on each of the forms.
- By using the MHS Web Portal Reconsideration process.
- Calling Provider Services at Phone: 1-877-647-4848; Provider Services hours 8 a.m. to 8 p.m.
- Requests received after day 67 will not be considered.



## **Informal Claims Dispute or Objection Form - Medical**



### Address:

Managed Health Services Post Office Box 3000 Attn: Appeals Department Farmington, MO 63640-3800

https://www.mhsindiana.com/content/da m/centene/mhsindiana/medicaid/pdfs/05 17.PR.P.FO%20Informal-Claim-Dispute-Objection-Form-EN-May2017.pdf



#### Informal Claim Dispute / Objection Form (Level I Administrative and Claims Appeals)

Use this form or your letterhead to file a written request to begin the Managed Health Services (MHS) informal claim dispute objection resolution process, in accordance with the MHS provider manual and Indiana regulations (405 IAC 1-1.6-1 through -1.6-6). This is Step 1 of the administrative or claim payment appeal process. You must pursue an informal dispute /objection before you may file a formal appeal.

The claim(s) in question must have originally been submitted to MHS in a timely manner

- . MHS contracted providers have 90 calendar days from date of service to file a claim Non-contracted providers have 365 calendar days from date of service to file a claim

The timely filling requirement in the case of claims for members with retroactive coverage, such as presumptively eligible

All providers have 67 calendar days from receipt of the MHS Explanation of Payment (EOP) to file an informal dispute, objection, or

- What-to-file check list:

  This form or written request for informal claims dispute / objection resolution on your letterhead.
- Copies of original MHS EOP showing how the claim(s) in question were processed. Copies of any subsequent MHS EOPs or other determinations on the claim(s) in question
- Documentation of any previous attempt you have made to resolve the issue with MHS.
- Other documentation that supports your request for reprocessing or reconsideration of the claim(s), such as:
  - Records or documentation previously requested by MHS to resolve the claim. · Proof of timely filing or documentation to support reasonableness of filing date. Rejections are not proof of
  - Documentation to support request for exception to MHS plan policy, benefit limitations and/or authorization

  - Documentation to support paying claims otherwise denied by coding or other audits

#### All fields are required:

) Number:
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eason for Informal Claims Dispute / Objection, including why you think MHS should pay the claim(s), adjust or reconsider hem and how the attached documentation supports your request. Attach additional sheets as needed

Send form or written Informal Dispute/Objection letter with relevant attachments by first class, priority or express U.S. mail to: Managed Health Services, Post Office Box 3000, Attn: Appeals Department, Farmington, MO 63640-3800

MHS will make all reasonable efforts to review your documentation and respond to you within 30 calendar days. If you do not receive a response within 30 calendar days, consider the original decision to have been upheld. At that time (or upon receipt of our response if sooner), you will have up to 67 calendar days from date on Explanation of Payment (EOP) to initiate a formal



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1-877-647-4848 | TTY/TDD: 1-800-743-3333 | mhsindiana.com liwell from MHS I Ambetter from MHS I Healthy Indiana Plan (HIP) I Hoosier Care Connect I Hoosier Healthwise



# Informal Claims Dispute or Objection Form – Behavioral Health





### Address:

Behavioral Health Services
 Post Office Box 6000

 Attn: Appeals Department
 Farmington, MO 63640-3809

https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/Behavioral-Health-Informal-Claim-Dispute-Objection-Form.pdf

#### Behavioral Health Informal Claim Dispute / Objection Form

(Level I Administrative and Claims Appeals)

#### Applicabilit

Use this form or your letterhead to file a written request to begin the Managed Health Services (MHS) informal claim dispute / objection resolution process, in accordance with the MHS provider manual and Indiana regulations (405 IAC 1-1.6-1 through 1-1.6-6). This is Step 1 of the administrative or claim payment appeal process. You must pursue an informal dispute /objection before you may file a formal appeal.

#### Time Limits/ When to File:

The claim(s) in question must have originally been submitted to MHS in a timely manner:

- MHS contracted providers have 90 calendar days from date of service to file a claim
   Non-contracted providers have 365 calendar days from date of service to file a claim
- The timely filing requirement in the case of claims for members with retroactive coverage, such as presumptively eligible pregnant women and newborns, is waived.

All providers have 67 calendar days from receipt of the MHS Explanation of Payment (EOP) to file an informal dispute, objection, or appeal with MHS.

#### What-to-file check list:

- This form or written request for informal claims dispute / objection resolution on your letterhead.
- Copies of original MHS EOP showing how the claim(s) in question were processed.
- Copies of any subsequent MHS EOPs or other determinations on the claim(s) in question
   Documentation of any previous attempt you have made to resolve the issue with MHS.
- Other documentation that supports your request for reprocessing or reconsideration of the claim(s), such as:
  - Records or documentation previously requested by MHS to resolve the claim.
  - Proof of timely filing or documentation to support reasonableness of filing date. Rejections are not proof of timely submission.
  - Documentation to support request for exception to MHS plan policy, benefit limitations and/or authorization
  - Documentation to support paying claims otherwise denied by coding or other audits

#### All fields are required

Provider Name:	Member Name:
Provider Tax ID#:	Member (RID) Number:
Requestor Name:	Requestor Title:
Date of this Request:	Requestor Phone Number:
Claim Number(s):	Date(s) of Service:

#### Whore to Eile:

Send form or written Informal Dispute/Objection letter with relevant attachments by first class, priority or express U.S. mail to: Behavioral Health Services, Post Office Box 6000, Attn: Appeals Department, Farmington, MO 63640-3809

MHS will make all reasonable efforts to review your documentation and respond to you within 30 calendar days. If you do not receive a response within 30 calendar days, consider the original decision to have been upheld. At that time (or upon receipt of our response if sooner), you will have up to 67 calendar days from date on Explanation of Payment (EOP) to initiate a formal claim appeal.



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1-877-647-4848 | TTY/TDD: 1-800-743-3333 | mhsindiana.com Allwell from MHS | Ambetter from MHS | Healthy Indiana Plan (HIP) | Hoosier Care Connect | Hoosier Healthwise



- Submit all documentation supporting your objection.
  - Copies of original MHS EOP showing how the claims in question were processed.
  - Copies of any subsequent MHS EOPs or other determinations on the claim(s) in question.
  - Documentation of any previous attempt you have made to resolve the issue with MHS.
  - Other documentation that supports your request for reprocessing or reconsideration of the claim(s).



- MHS will make all reasonable efforts to review your documentation and respond to you within 30 calendar days.
- If you do not receive a response within 30 calendar days, consider the original decision to have been upheld.
- At that time (or upon receipt of our response if sooner), you will have up to 67 calendar days from date of Dispute response to initiate a formal claim appeal (Step 2).



- W Helpful Tips:
  - Disputing multiple claim denials:
    - Submit separate Informal Claims Dispute Forms for each member/patient experiencing the denial;
    - Provide additional information such as:
      - The MHS denial code and description found on the EOPP/remit;
      - Briefly describe why you are disputing this denial;
      - For multiple claims please either list all claim numbers or in the "Reason for Dispute" section state that "member is experiencing denial reason \_\_\_\_ for all claims DOS\_\_\_\_ to \_\_\_\_; Please review all associated claims";
  - Save copies of all submitted informal claims dispute forms.



# Formal Claim Dispute - Administrative Claim Appeal

### Step 2

- Step 2 is a continuation of Step 1 and is a Formal Claim Dispute, Administrative Claim Appeal.
- In the event the provider is not satisfied with the informal claim dispute/objection resolution, the provider may file an administrative claim appeal. The appeal must be filed within 67 calendar days from receipt of the informal dispute resolution notice.
- An administrative claim appeal must be submitted in writing on company letterhead with an explanation including any specific details which may justify reconsideration of the disputed claim. The word "appeal" must be clearly marked on the letter.



# Formal Claim Dispute - Administrative Claim Appeal

### Step 2

- Administrative claim appeals need to be submitted to: Managed Health Services, P.O. Box 3000, Farmington, MO 63640
- See the MHS Provider Manual Chapter 5 Claims Administrative Reviews and Appeals for more information. <a href="https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/Provider\_Manual\_2019.pdf">https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/Provider\_Manual\_2019.pdf</a>



## **Arbitration**

### Step 3:

- Step 3 is a continuation of Steps 1 & 2 and is a part of the formal MHS Provider Claims dispute process.
- In the event a provider is not satisfied with the outcome of the administrative claim appeal process (Step 2), the provider may request arbitration. Claims with similar issues from the same provider may be grouped together for the purpose of requesting arbitration.
- To initiate arbitration, the provider should submit a written request to MHS on company letterhead. The request must be postmarked no later than 60 calendar days after the date the provider received MHS' decision on the administrative claim appeal.
- Arbitration Requests need to be mailed to, MHS Arbitration, 550 N. Meridian Street, Suite 101, Indianapolis, IN 46204, unless otherwise directed in the letter.
- See the MHS Provider Manual Chapter 5 Claims Administrative Reviews and Appeals for more information.

  https://www.mbsindiana.com/content/dam/content/mbsindiana/modicaid/pdfs/Provide
  - https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/Provider\_Manual\_2019.pdf



# Provider Services Phone Requests & Web Portal Inquiries

- This is not considered a formal notification of provider dispute.
- Claim issues presented by providers to the Provider Services phone line & Web Portal Inquiries for review will be logged and assigned a ticket number; Please keep this ticket number for your reference
- **Phone:** 1-877-647-4848; Provider Services 8 a.m. to 8 p.m.
- **Provider Web Portal:** <a href="https://www.mhsindiana.com/providers/login.html">https://www.mhsindiana.com/providers/login.html</a>
  - Use the Messaging Tool.



# **Customer/Provider Services Phone Requests & Web Portal Inquiries**

- W Helpful Tips:
  - Disputing multiple claim denials:
    - Provide the provider services rep or web portal team member with one claim number as an example of the specific denial.
    - Communication is Key!
      - Tell the rep you have a "claims research request" to review all claims for the specific denial reason.
      - State if this denial is happening for one or multiple practitioners within your group or clinic; (if multiple, provide your TIN)
      - Provide the MHS denial code and description found on the EOP.
      - Briefly describe why you are disputing this denial or seeking research.



## **Paper Claim Corrections**

A corrected claim can be submitted following IHCP claim adjustment processes.

A claim adjustment code is required on all claims, based on the type of claim submitted.

- Example: Frequency 7 entered in Box 22 of the CMS 1500 form.
- Example: Frequency 7 used as the last digit for the bill type on a UB04 form (i.e. 1x7)

The original claim number must also be listed on the corrected claim.

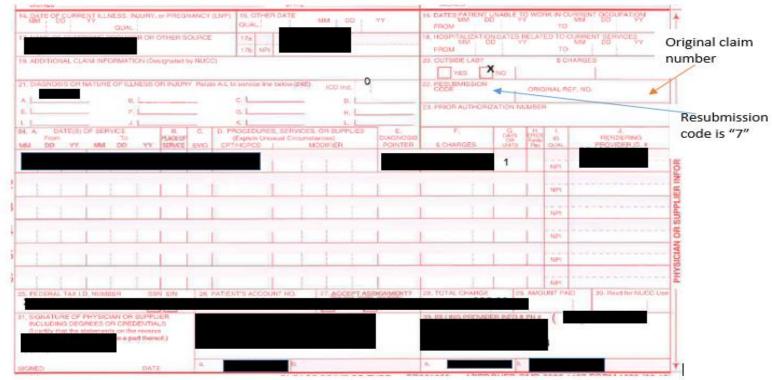
- Box 22 on the CMS 1500 and box 64 on the UB04.
- Remember a rejection, must be submitted as 1<sup>st</sup> time claim, not as a corrected claim.

Handwriting or stamping on a claim will not be accepted as submission of a corrected claim, and will be rejected with code RE.



## **Paper Claim Corrections**

- If you must submit via paper never handwrite "corrected claim" on the claim form.
- Complete box 22 (Resubmission Code) to include a 7 (the "Replace" billing code) to notify us of a corrected or replacement claim.





## **EFTs and ERAs**

## MHS uses Payspan Health for:

- Web based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs)
- **One** year retrieval of remittance advice
- Provided at no cost to providers and allows online enrollment
- Register at payspanhealth.com:
  - For questions call 1-877-331-7154 or email providersupport@payspanhealth.com



## **Prior Authorization**



## **Authorization Considerations**

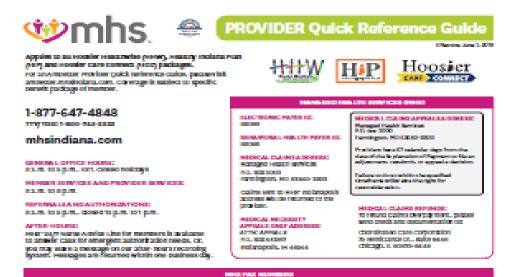
- Need to know what requires Authorization:
  - Reference QRG
  - Pre-Authorization tool
- How to obtain Authorization:
  - Online (excluding Home Health and Hospice requests)
  - Phone
  - Fax
- **W** Authorizations do not guarantee payment



#### **Prior Authorization**

#### Is Prior Authorization Needed?

- MHS website: mhsindiana.com
- Quick reference guide
- Non-contracted provider services now align with PA requirements for contracted providers



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#### **Prior Authorization**

<u>Some</u> services that require prior authorization regardless of contract status (not inclusive) are:

- All elective hospital admissions
- All urgent and emergent hospital admissions (including NICU) require notice to MHS following the admission.
- Transition to hospice
- Newborn deliveries (Notification Required)
- Rehabilitation facility admissions
- Skilled nursing facility admissions
- Transition of care
- Transplants, including evaluations
- Physical Therapy, Occupational, and Speech Therapy

Reference QRG for a more detailed listing

- Injectable drugs (see <u>mhsindiana.com/provider-guides</u> for up-to-date list of codes)
- Nutritional counseling (unless diabetic)
- Pain management programs, including epidural, facet and trigger point injections
- PET, MRI, MRA and Nuclear Cardiology/SPECT scans
- Cardiac rehabilitation
- Hearing aids and devices
- Home and Institutional hospice (coverage varies by product)
- In-home infusion therapy
- Orthopedic footwear
- Respiratory therapy services
- Pulmonary rehabilitation
- Home care (except after an IP admission with benefit limitations)



#### **Utilization Management**

#### MEDICAL NECESSITY GRIEVANCE AND APPEALS

Managed Health Services
Attn: Appeals Coordinator
PO BOX 441567
Indianapolis, IN 46244

- Determination will be communicated to the provider within 20 business days of receipt.
- Remember: Appeals must be initiated within 60 days of the denial to be considered. Please note, this is different than a claim appeal request.



## **Behavioral Health Prior Authorization**

- Prior Authorization
  - Please call Care Management for inpatient and partial hospitalization authorizations at 1-877-647-4848. Follow prompts to Behavioral Health.
  - · Authorization forms may be obtained on our website
    - Outpatient Treatment Request (OTR) Form/Tip-Sheet/Training
    - Intensive Outpatient/Day Treatment Form Mental Health/Chemical Dependency
    - Applied Behavioral Analysis Treatment
    - Psychological Testing Authorization Request Form (Outpatient & Inpatient)
- Medical Necessity Appeals
  - Submit to:

MHS Behavioral Health ATTN: Appeals Coordinator 12515-8 Research Blvd, Suite 400 Austin, TX 78759



## **Behavioral Health Services Requiring Authorization**

#### **Professional Services**

- Psychiatric Diagnostic Evaluation (Limited to 1 per member per 12 month Rolling year without authorizaton)
- Electroconvulsive Therapy
- Psychological Testing (Unless for Autism: then no auth is required)
- Developmental Testing, with interpretation and report (non-Early Periodic Screening, Diagnosis Treatment EPSDT)
- Neurobehavioral status exam, with interpretation and report
- Neuropsych Testing per hour (face to face) (Unless for Autism: then no auth is required). (Non-Participating Providers only)
- Applied Behavioral Analysis (ABA) Services



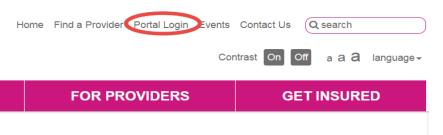
## Portal Functionality



## **Secure Web Portal Login or Registration**

Use Login/Register is the same for MHS, Ambetter from MHS, Allwell from MHS and Behavioral Health Providers





# FOR PROVIDERS Login Become a Provider Prior Authorization Dental Providers Pharmacy Behavioral Health Provider Resources QI Program Provider News

#### Portal Login

FOR MEMBERS



If you are having trouble with your registration, you may need to submit a non-par set-up form. Visit our <u>Become a Provider</u> page to get started. For further assistance, you can call our Secure Provider Portal Help Line at 1-866-912-0327.

#### Create your own online account today!

MHS offers you many convenient and secure tools to assist you. To enter our secure portal, click on the login/register button. A new window will open. You can login or register for a new account.

Creating an account is free and easy.

By creating a MHS account, you can:

- Verify member eligibility
- Submit and check claims
- Submit and confirm authorizations
- View detailed patient list

Please note that Clear Claim Connection does not provide an all inclusive listing of claim edits. MHS does utilize additional prepayment review edits in keeping with NCCI procedures and guidelines.



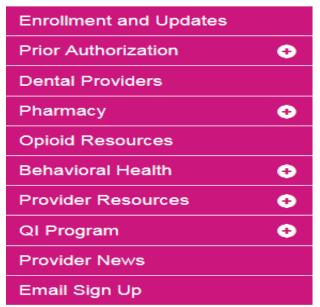
#### **Web Portal Training Documents**

#### Documents Include:

- Registration Guide
- MHS Web Portal User Guides
- How To Complete Specific Tasks on the MHS Web Portal

#### FOR PROVIDERS

#### Login



#### PORTAL TRAINING GUIDES



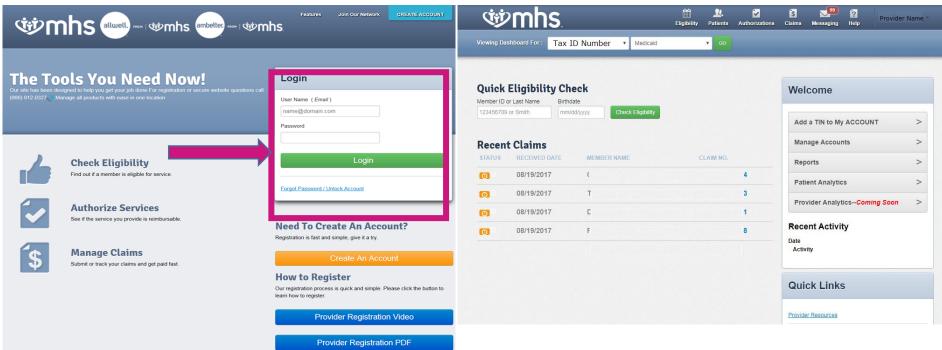
- Account Manager User Guide (PDF)
- Provider Secure Portal Brochure (PDF)
- Provider Secure Portal Flyer (PDF)
- Submit a Claim CMS 1500 (PDF)
- Submit a Claim CMS UB-04 (PDF)
- Submit a Corrected Claim (PDF)
- Update Portal Account Details (PDF).
- <u>Utilize Member Management Forms (PDF).</u>
- View Claim Status (PDF)
- View Payment History (PDF)

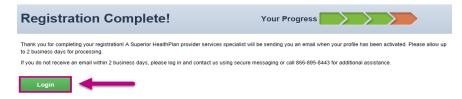
#### Registration Help

If you are having trouble with your registration, you may need to submit a non-par set-up form. Visit our <u>Become a Provider</u> page to get started. For further assistance, you can call Provider Services at 1-877-647-4848 or see our <u>Account Registration Guide (PDF)</u>.



#### **Complete Registration or Login**

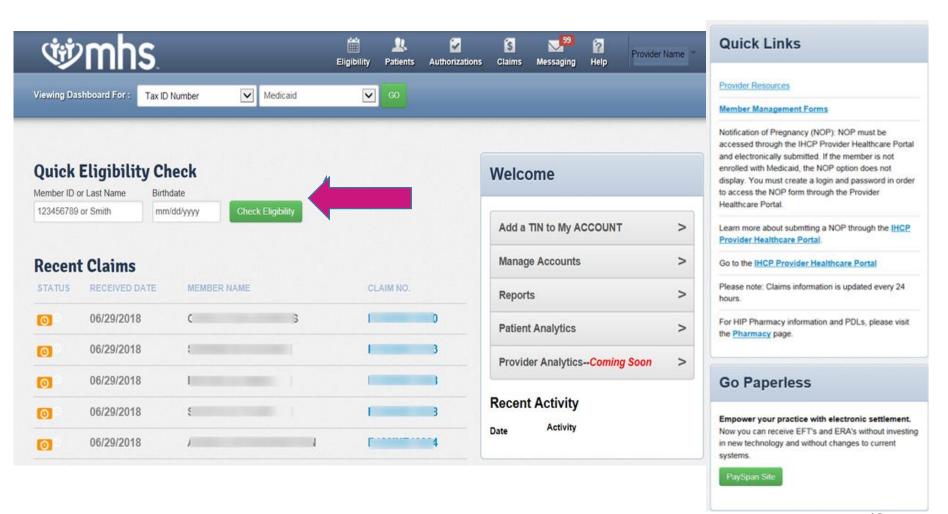




 An email will be sent to the provider when they have access to specific tools. The Registration is complete and the Secure Portal homepage will be visible!



#### Homepage - MHS (Medicaid)





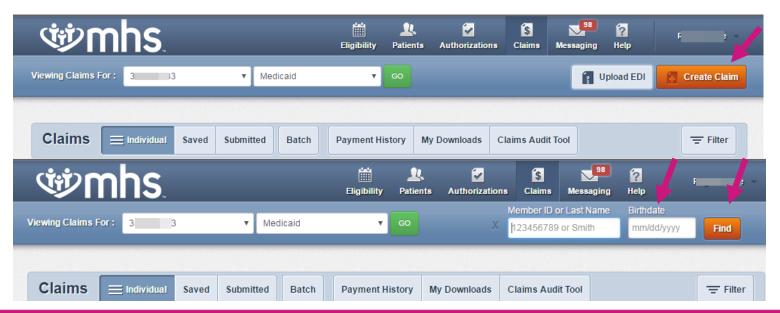
#### **Claims**

#### **Web Portal Claims Functionalities:**

- Submit new claim.
- Review claims information on file for a patient.
- Correct claims.
- View payment history.

#### **Submit a New Claim:**

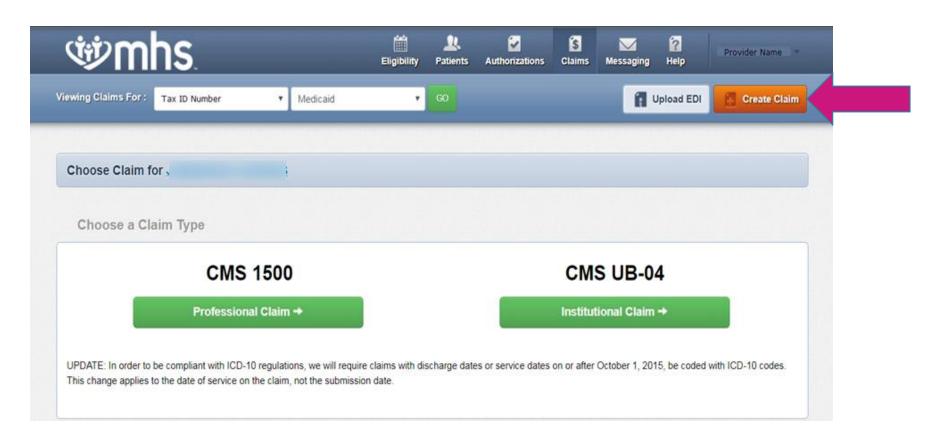
Click Create Claim and enter Member ID and Birthdate





#### **Claim Submission**

- **W** Choose the Claim Type
  - Professional or Institutional claim submission

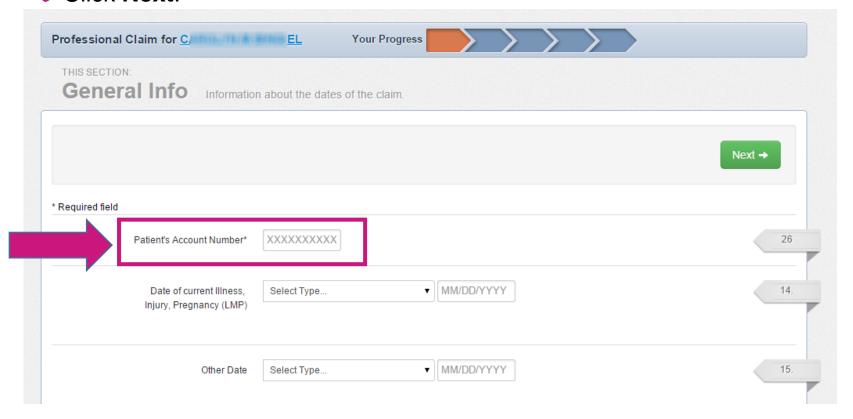




#### **Professional Billing**

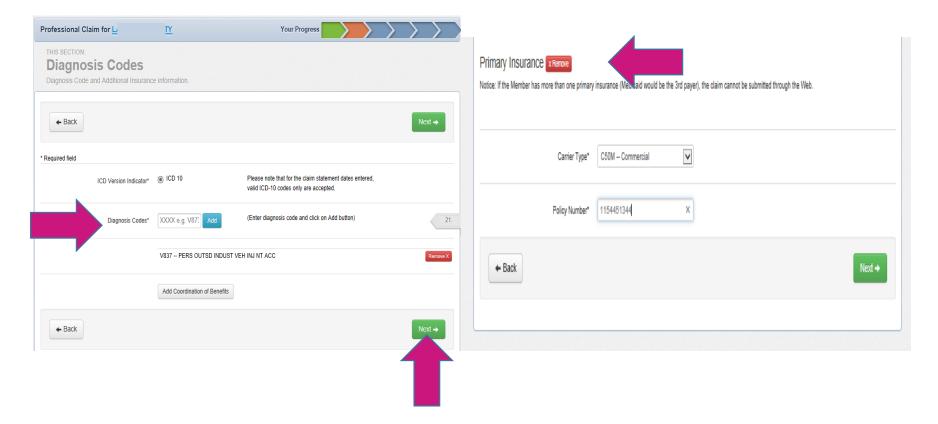


- In the General Info section, populate the Patient's Account Number and other information related to the patient's condition by typing into the appropriate fields.
- **W** Click **Next**.



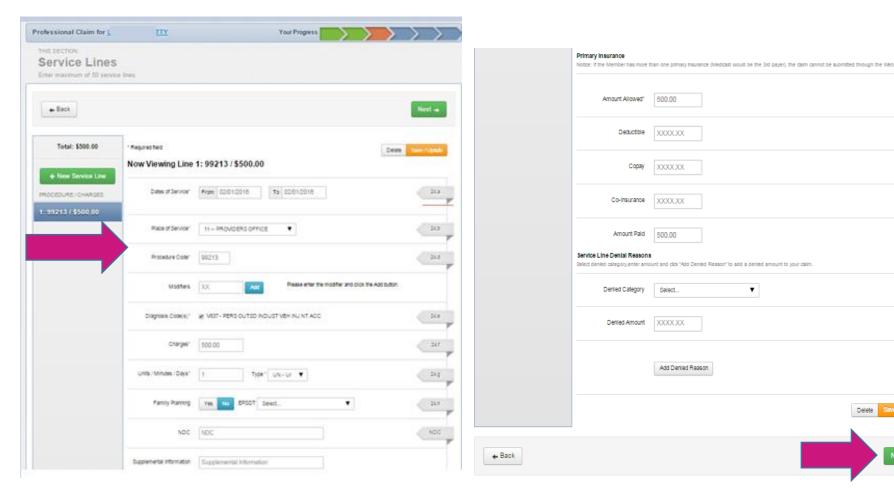


- Add the **Diagnosis Codes** for the patient in Box 21.
- Click the **Add** button to save.
- Click Add Coordination of Benefits to include any payments made by another insurance carrier (if applicable).



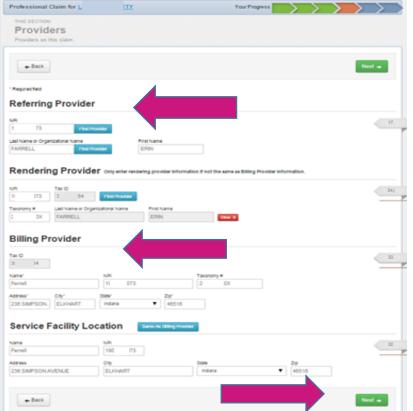


Add Service Lines.

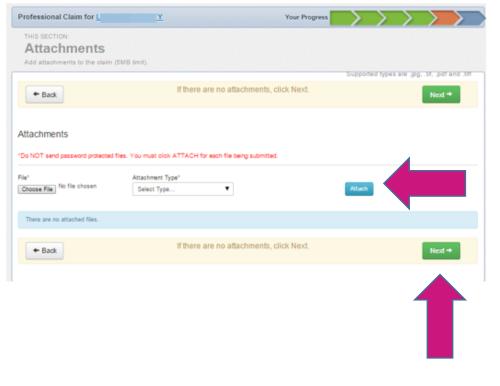




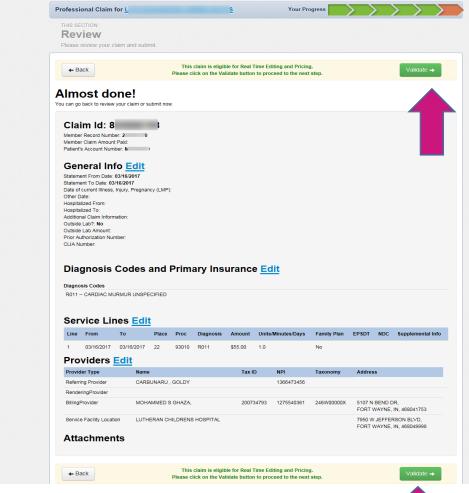
- Enter Referring and Billing Provider information. Enter Service Facility Location.
- **W** Click **Next**.



- In the Attachments section you can **Browse** and **Attach** any documents to the claim as desired. (Note: If you have no attachments, skip this section.)
- **W** Click **Next**.





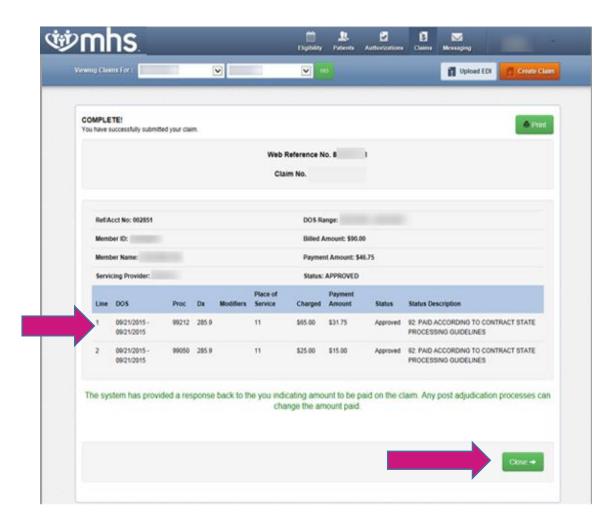


- In the **Review**section, you can see if the claim is eligible for Real Time Editing and Pricing (RTEP).
- Click Validate for RTEP Claims and Click Submit for regular processed claims.





#### **RTEP Claim Pricing View**



#### **WRITEP Overview:**

- On the final screen, each procedure code will receive a reimbursement estimate, pending claim explanation or denial reason.
- Claims with a reimbursement estimate or pend explanation, may be impacted by final adjudication including a change to the reimbursement amount or a denial.
- Adjudication status may be affected by Code Editing or other payment rules.

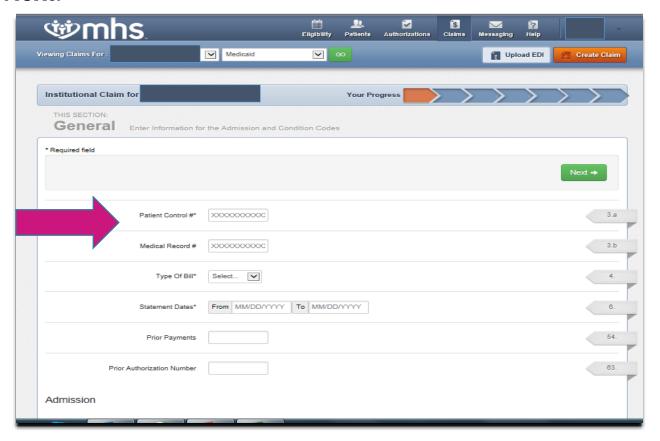


#### **Facility Billing**



#### **UB-04** Billing

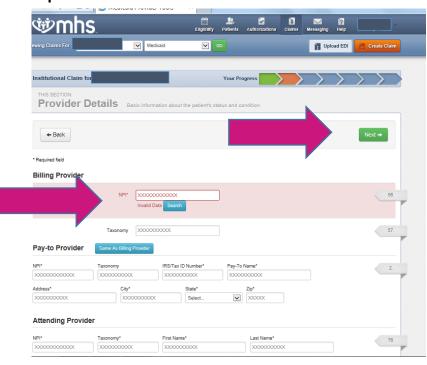
- In the General Info section, populate the Patient's Control Number and other information related to the patient's condition by typing into the appropriate fields.
- **W** Click **Next**.



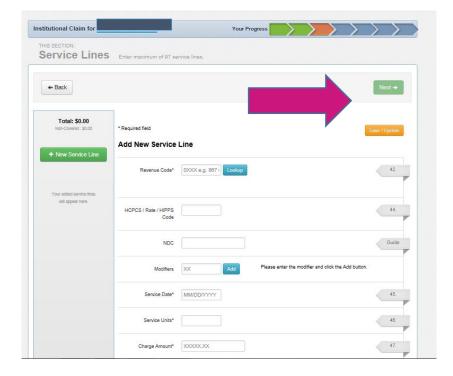


#### **UB Billing**

- Add the provider information.
- Click save and click next to proceed

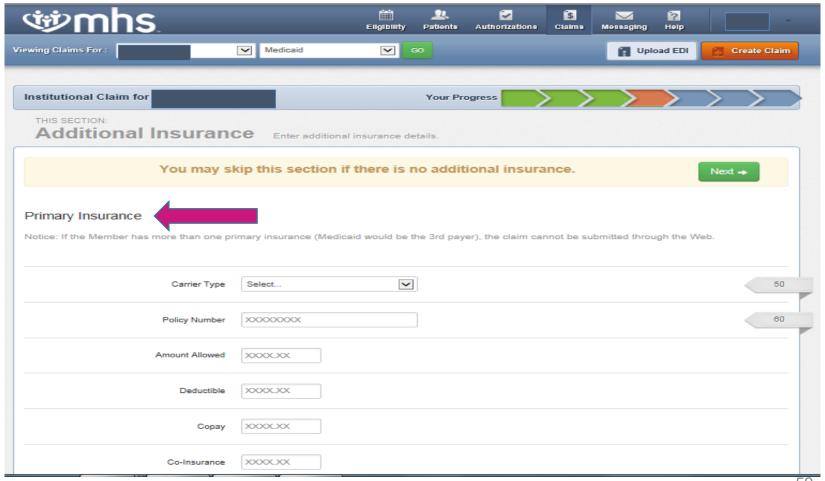


Click Add New Service Line and enter the service lines information.



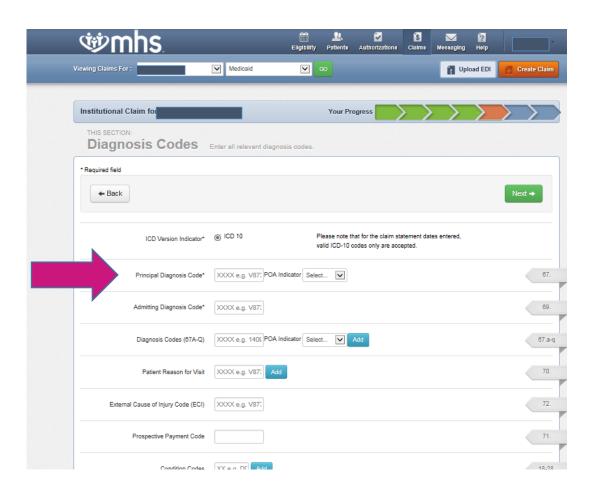


#### Enter Additional Insurance (if applicable)



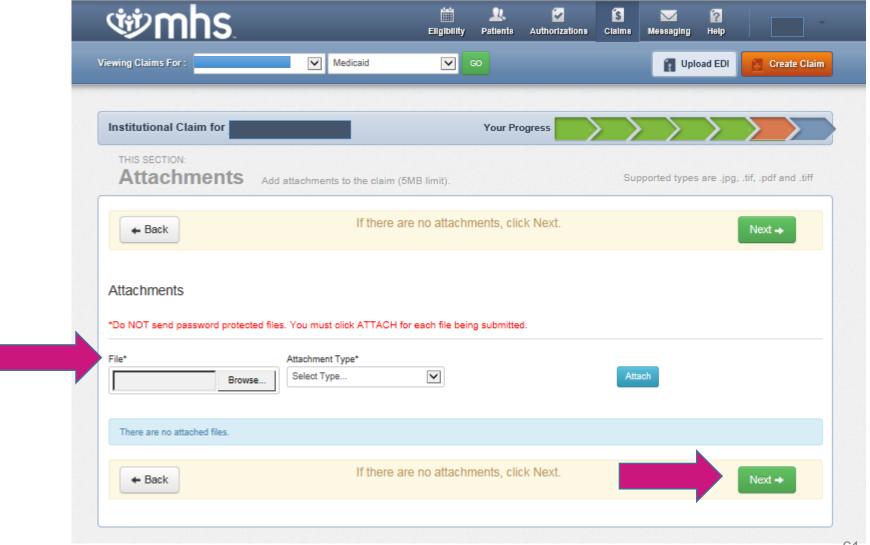


#### Enter Diagnosis Codes (use Add button)





#### Add Attachments (if applicable)





#### **Review Claim and Submit**



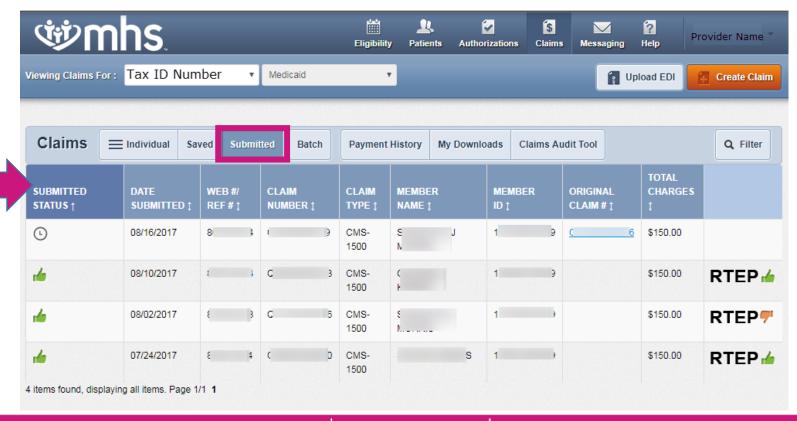


## Web Portal Claim and Payment Review



#### **Submitted Claims**

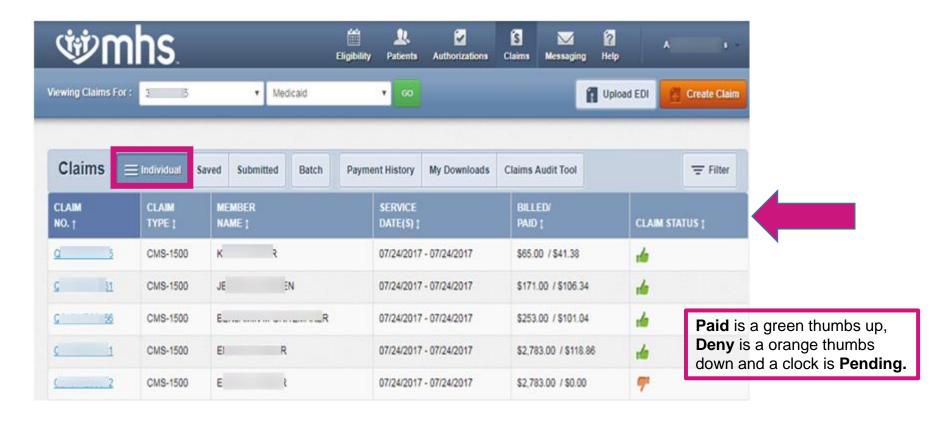
- The **Submitted** tab will only display claims created via the MHS portal:
  - Paid is a green thumbs up.
  - Denied is an orange thumbs down.
  - **Pending** is a clock.
- **RTEP** claims also show if eligible (i.e. line 3 was submitted, but was not eligible for RTEP).





#### **Individual Claims**

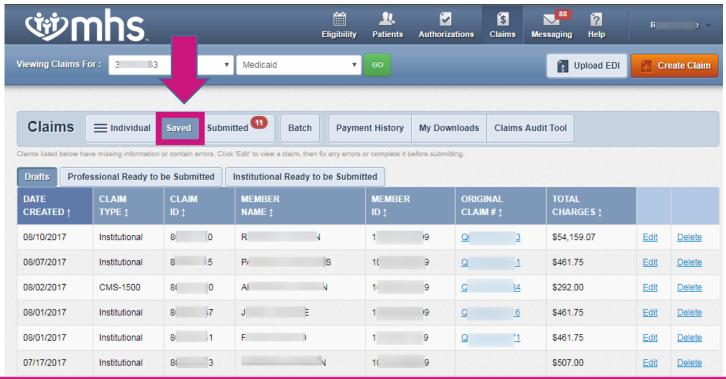
- On the Individual tab, submitted using paper, portal or clearing house:
  - View the Claim No, Claim Type, Member Name, Service Date(s), Billed/Paid, and Claim Status





#### **Saved Claims**

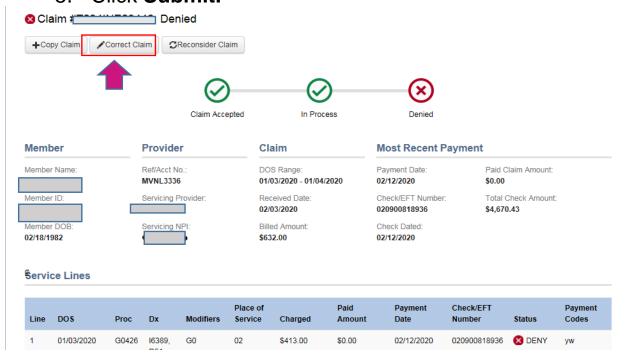
- To view **Saved** claims: Drafts, Professional or Institutional:
  - 1.Select Saved.
  - 2.Click Edit to view a claim.
  - 3. Fix any errors or complete before submitting.
  - 4. Click **Delete** to delete saved claim that is no longer necessary.
  - 5. Click **OK** to confirm the deletion.





#### **Correcting Claims**

- After clicking on a Claim # link:
  - 1. Click Correct Claim.
  - 2. Proceed through the claims screens correcting only the information that you may have omitted when the claim was originally submitted. Do not change anything else.
  - 3. Continue clicking **Next** to move through the screens required to resubmit.
  - Review the claim information.
  - Click Submit.



Only claims with a status of PAID or DENY can be corrected online.



## Online Claim Reconsiderations on the MHS Secure Provider Portal



#### **Summary Of Online Reconsiderations**

#### Skip the phone call.

Providers can make their case directly on the portal.

#### **W** Make the case.

Providers can submit informal dispute/reconsideration comments using expanded text fields.

#### Add context.

Providers can easily attach supporting documentation when filing an informal dispute/reconsideration.

#### Stay current.

- Providers may opt in/out for informal dispute/reconsideration status change emails.
- Providers may also view status online.



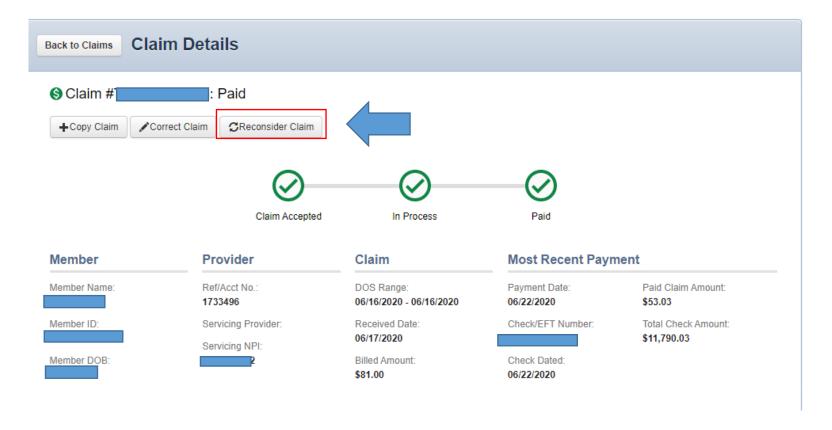
#### **Online Reconsiderations**

- Providers may now view EX code information.
- Providers will be able to:
  - Submit informal disputes/reconsiderations on the secure portal.
  - Upload/view supporting documents
  - View acknowledgement letters
  - Track real time updates



#### **Online Reconsiderations**

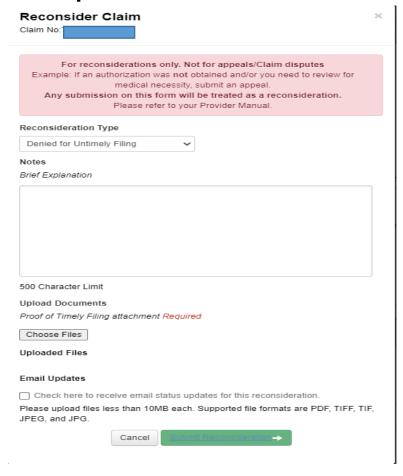
**Select Reconsider Claim** 





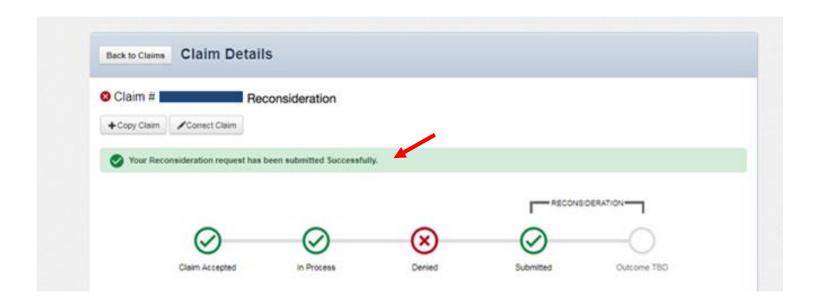
#### **Claim Reconsiderations**

Enter your Explanation for reconsideration and check Email Updates



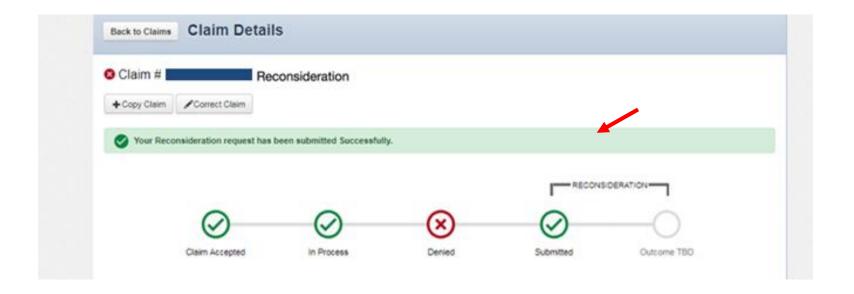


Upon submission, a success banner will be displayed.

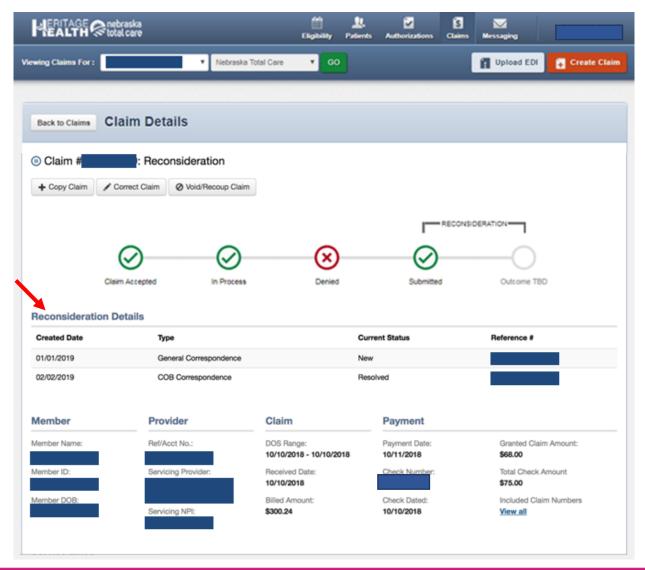




The tracker graphic will be updated to reflect that a reconsideration is in progress.

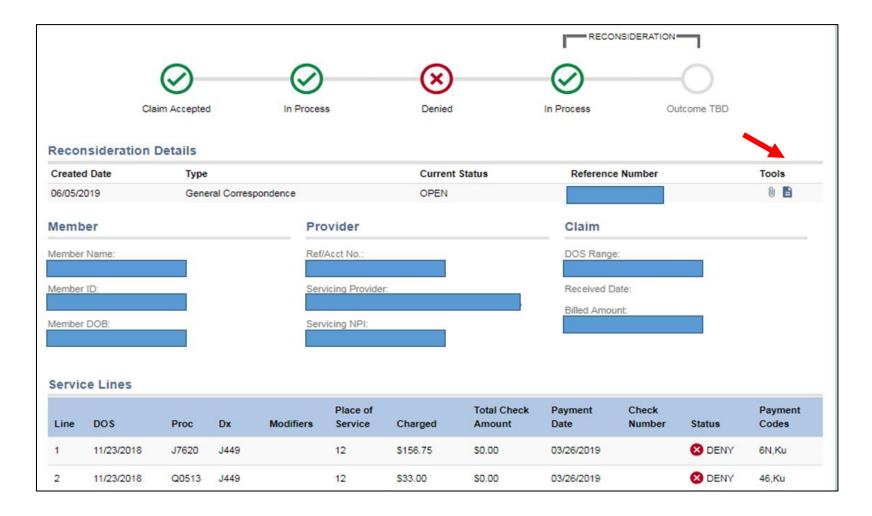








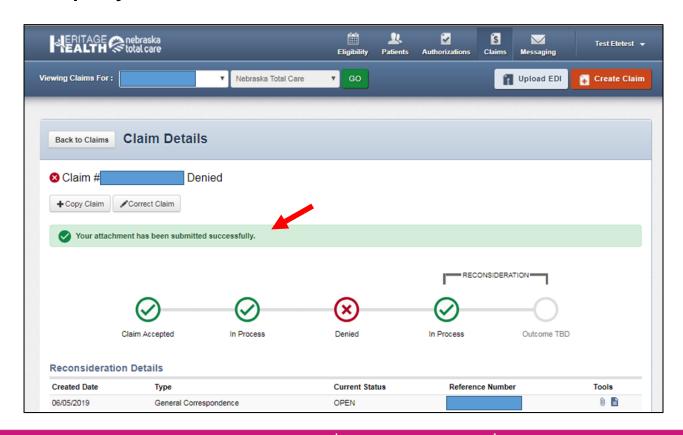
# Online Reconsiderations Additional Attachments





# Additional Attachments – Success Banner

Upon successful upload of files, a success banner is displayed.



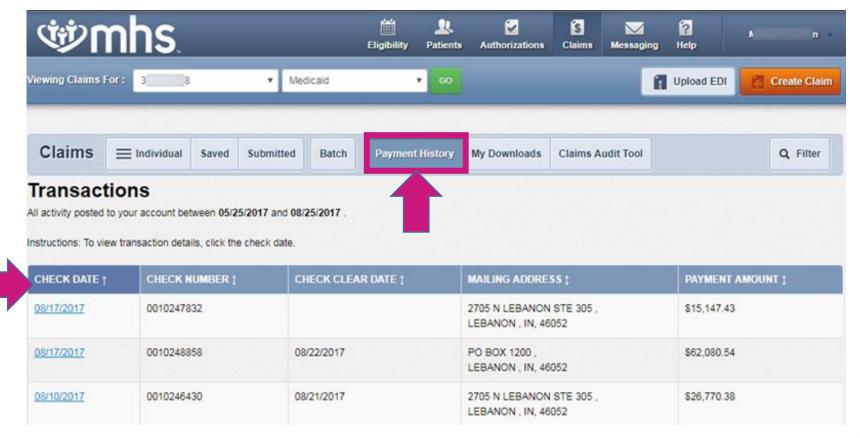


- It is important to note that all requests submitted via the reconsideration tool will be considered an informal dispute.
- Calling Provider Services will not pause the time frame for timely submissions for informal disputes.
- Providers do not need to call prior to submitting an online claim reconsideration/information dispute.
- Providers may include a dispute form, but it is not required, as they may include comments directly into the portal.



# **Payment History**

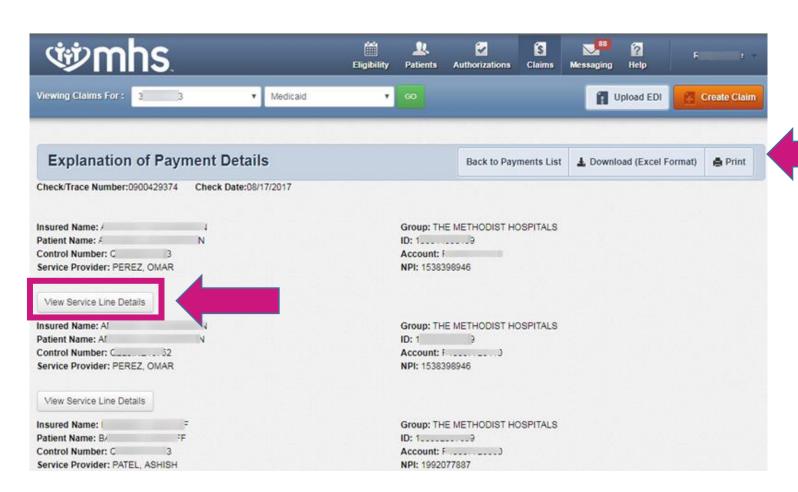
- Click on Payment History to view Check Date, Check Number, Check Clear Date, Mailing Address and Payment Amount
  - Click on Check Date to view Explanation of Payment





# **Payment History**

**W** Click on View Service Line Details.



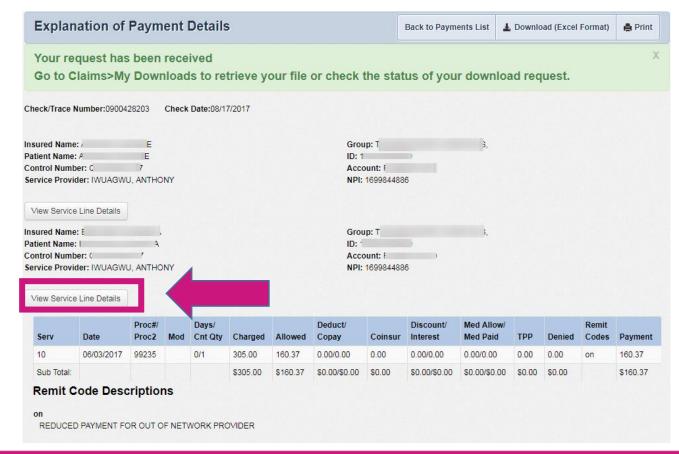


# **Payment History**



#### View Service Line Details:

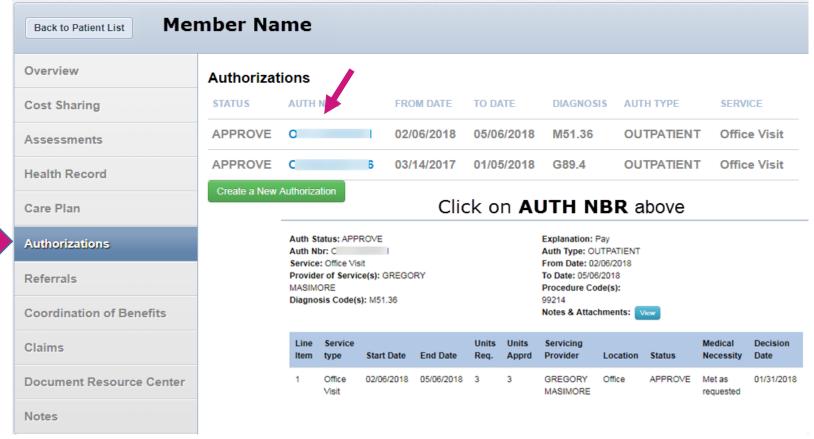
- The **Explanation of Payment Details** displays the Date and Check Number/Trace number.
- This view shows each patient payment by service line detail made on the check.





# **Authorizations**

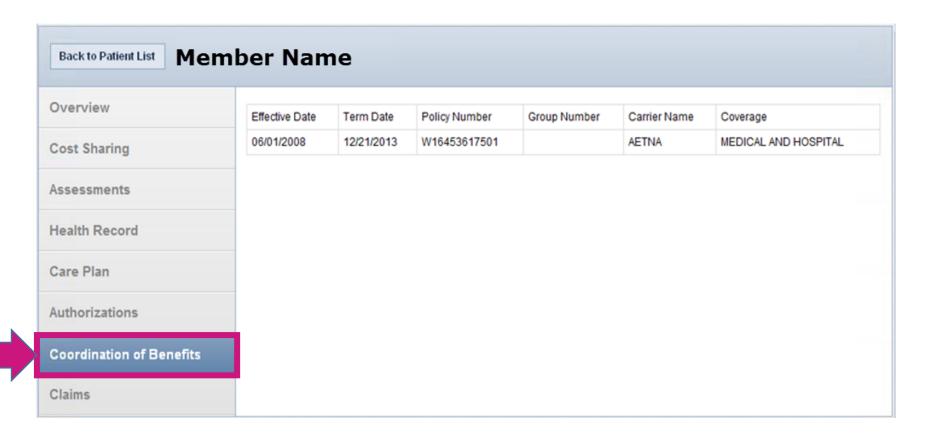
View previously submitted or Create a New Authorization.





# **Coordination of Benefits**

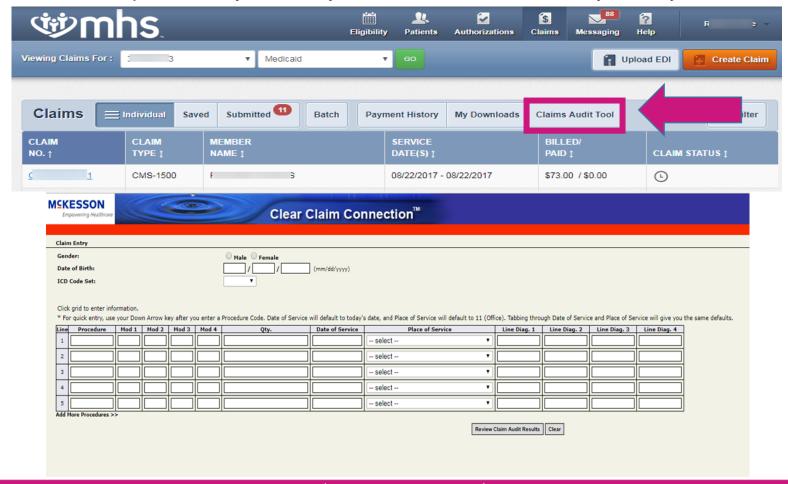
This screen shows if a member has other insurance.





# **Claims Audit Tool**

The Clear Claim Connection screen appears, allowing you to enter the Procedure Code, Quantity, Modifiers, Date and Place of Service, and Diagnosis for a claim proactively before you submit or retroactively after you submit.





# **Tips to Remember**

- Clicking on items (claim numbers, check numbers, dates) that are highlighted blue will reveal additional information.
- When filtering to find a claim or payment, only a 1 month span can be used.
- Click on the **Saved Claims** tab to view claims that have been created but not Submitted. Claims in this queue can be edited for submission or deleted from this tab.
- In order to utilize the Correct Claim feature, the claim needs to be in a Paid or Denied status.
- When filtering Payment History the span is limited to 1 month.



# **MHS Team**



#### **MHS Provider Network Territories**

#### Indiana **NORTHEAST REGION** For claims issues, email: MHS\_ProviderRelations\_NE@mhsindiana.com Chad Pratt, Provider Partnership Associate Noble DeKalb 1-877-647-4848, ext. 20454 **NORTHWEST REGION** For claims issues, email: MHS\_ProviderRelations\_NW@mhsindiana.com Aller Fulton Candace Ervin, Provider Partnership Associate Pullaski 1-877-647-4848, ext. 20187 NORTH CENTRAL REGION For claims issues, email: MHS\_ProviderRelations\_NC@mhsindiana.com Natalie Smith, Provider Partnership Associate 1-877-647-4848, ext. 20127 **CENTRAL REGION** For claims issues, email: Tippecanos Warren MHS\_ProviderRelations\_C@mhsindiana.com Tipton Mona Green, Provider Partnership Associate 1-877-647-4848, ext. 20080 Randolph Madiso SOUTH CENTRAL REGION Montgomer For claims issues, email: MHS\_ProviderRelations\_SC@mhsindiana.com Wayne Dalesia Denning, Provider Partnership Associate 1-877-647-4848, ext. 20026 SOUTHWEST REGION Rush For claims issues, email: MHS\_ProviderRelations\_SW@mhsindiana.com Dawn McCarty, Provider Partnership Associate Vigo Morgan Franklin 1-877-647-4848, ext. 20117 **SOUTHEAST REGION** For claims issues, email: MHS\_ProviderRelations\_SE@mhsindiana.com Sullivan Carolyn Valachovic Monroe Provider Partnership Associate 1-877-647-4848, ext. 20114 Switzerland **mhs**

#### **Available online:**

https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/ProviderTerritory\_map\_2020.pdf

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#### PROVIDER GROUPS

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#### **Available online:**

https://www.mhsindiana .com/content/dam/cent ene/mhsindiana/medica id/pdfs/ProviderTerritory \_map\_2020.pdf

**Back of Map** 

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# **Summary**

We hope you learned more about the following topics:

- Ease of claim submission with MHS
- How to timely submit claim adjustments electronically
- Tips on how to successfully problem solve claim rejections
- Steps for researching claim denial issues
- How to effectively navigate the MHS Portal
- Details about Dispute Resolution process
- Who to contact for assistance at MHS



Thank you for being our partner in care.